August 1997

Clinical Center News

In this issue:

Projects serve up an era of change for building 10

The face of the Clinical Center is about to change forever.

First up is construction of the south entry, which will serve as the CC's main front door for the duration of the project. That begins this month.

"Actual construction of the new entry and drive should be completed by April 1998," noted Yong-Duk Chyun, CRC project director for NIH. "Between April and August of next year, associated mechanical work will be completed."

Construction of the new building to the north will begin in October. Initial site preparations include demolition of building 20, relocation of utilities, and realignment of Center Drive. That work will continue until next June, when actual excavations will get under way.

All these construction phases will have specific consequences for campus parking, officials note. *(See story on parking, page six.)*

Watch for signs specifying what construction involves and how it will affect parking and building access. Other communications efforts are planned. "We want to make sure that everyone is kept informed about the project and how it will affect day-to-day operations," Chyun explained.

Board recommends CC budget, hears reports on strategic plan

The Clinical Center's Board of Governors unanimously voted to recommend approval of the CC's $224 million budget for FY98 during their meeting here July 10. It goes next to Dr. Harold Varmus, NIH director, for his consideration.

Personnel costs consume most of the proposed budget pie. "Total personnel costs for '98 are $136.7 million or 61 percent of the budget when both contract and government FTE costs are included," Dr. John Gallin, CC director, pointed out.

"The contract service element, which is 17 percent of the total budget, is the next major expenditure and it's made up of all the maintenance contracts for sustaining equipment, repairs, utilities, plant maintenance, and off-campus rental facilities."

The budget also sets aside $32.1 million for supplies and $5.8 million

See **board meeting,** page seven

A towering profession

George Simmons (left) operates one of the tower cranes that's been looming over the Clinical Center for the past few months. NIH staff physician Dr. Alan Zametkin (right) wanted to know more. See pages four and five. (Photo by Bill Branson)

from the director

by Dr. John I. Gallin
CC director

At NIH, Boards of Scientific Counselors review our science. They assess research that's proposed and in progress. They evaluate the productivity and performance of staff investigators. The purpose is to make sure that research at NIH is efficient and of the highest possible quality.

Similarly, we at the Clinical Center need a formal mechanism to take a long, hard look at our operations and how we function as an organization in order to be efficient and productive while preserving the quality of science and research. That is why I have proposed a new departmental review process to the CC Board of Governors that will help CC departments evaluate and improve their individual operations.

My goal is to have a very frank and constructive review process of the operational aspects of each department to find out what is working well within the Clinical Center and what needs fixing.

I've proposed a rotating schedule of reviews that would ensure a top-to-bottom survey of departmental performance once every three years.

The survey team will include internal and external experts experienced in the individual areas they will survey. Users of departmental services may be included on the team and certainly will be able to provide input. A member of the Board of Governors will head the group.

The Clinical Center's new chief financial officer, Michele Lagana, *(See story page eight)* is leading a team of CC and NIH staff to refine our structure of review, define how to use the information we discover, and develop and evaluate subsequent efforts to improve department performance.

Evaluation results will be presented to the Board of Governors. One of the board's charges is to evaluate the performance of the Clinical Center. How well departments work in serving NIH's patient-care, research, and administrative needs is a critical element of that performance.

The Clinical Center has never had a process in place to conduct this systematic review of department operations. I believe this will be a constructive and valuable process for us all.

Long-time CC employee dies just before retirement; memorial held

Co-workers, family, and friends of the late Jesse J. Ferguson crowded into Masur Auditorium on July 8 for a service in his memory.

Ferguson died days before his planned retirement from federal service. A native of Nacogdoches, Texas, he began his federal career at the Clinical Center in 1961. He began with the local-transportation section, working through the ranks serving as chief of the patient escort service, chief of the admissions section and as clinic administrator, and deputy chief of the Outpatient Department.

Although he lived in the Washington area for nearly 40 years, Ferguson, the memorial program noted, remained a Texan at heart and was a devoted Dallas Cowboys fan.

"He dedicated himself to the patients and mission of the Clinical Center and his zeal to ensure compassionate, efficient patient care guided his every action. He could be found at work days, nights, weekends, and holidays, sometimes in his white lab coat, others in his baseball cap and bib overalls."

He also found time to volunteer with D.C. youth programs and he coached youth and men's football teams.

Those wishing to make contributions to a memorial fund may contact Nancy Schulze or Gracie Millender in the Outpatient Department. The phone number is 496-2341. The memorial fund will benefit youth programs at the Lamond Riggs Community Center.

Memorial services were held last month for Jesse Ferguson, a long-time CC employee.

Clinical Center News

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Clinical Center News, Building 10, Room 1C255, National Institutes of Health, Bethesda, Maryland 20892. (301) 496-2563. Fax: 402-2984. Published monthly for CC employees by the Office of Clinical Center Communications, Colleen Henrichsen, chief. News, article ideas, calendar events, letters, and photographs are welcome. **Deadline** for submissions is the second Monday of each month.

the fax, please

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Fax your comments, questions, observations, and ideas about making the Clinical Center a better place to work to: **402-2984.** We'll include the feedback and responses from the CC director in future issues. No names will be used.

optional info:

Name: _____

Fax/phone/email_____

answers

Last month's reminder of the Clinical Center's smoking policy prompted the following comments from readers:

From a staff member: On numerous occasions I have noticed people smoking in front of the Clinical Center and the police officer on duty doing nothing about it. Are you serious about enforcing the smoking policy? Signs have been installed but some people—sometimes patients—can't read or choose to ignore the no-smoking signs. I, for one, would appreciate stricter enforcement. Let's practice what we preach.

From a staff member: I've been working in the NIH library for the last five years. I think the July 1995 restriction on smoking around the CC has done very little to curb the horrible smell of smoke creeping into the hallway outside the library, and consequently the library itself. The main reason, I believe, is the lack of any security enforcing the law. Smokers, especially patients and non-staff persons, constantly light up right outside the entrance and sometimes even inside. The main issue, get some security presence in the back of building 10, start seriously enforcing the smoking restrictions outside the library, push the smokers outside from under the canopy and the overhang outside the cafeteria. Make this truly the National Institutes of Health.

From a patient: I've been a patient here for nine years and appreciate all the good work that goes on here. I sometimes think that the smoking-related littering is in part a protest on the part of the smokers. We haven't been provided with ash receptacles so that we can properly dispose of the smoking litter and there's no comfortable, protected seating provided to encourage smokers to move away from the building.

The CC director responds:

Asking for NIH police assistance in enforcing our smoking policy is an avenue that I will pursue with NIH and police officials. Signs indicating where smoking is not permitted are in place and we'll add more as needed. Ash receptacles are located along the perimeter of the building. If more are needed in different places, fax the suggested locations to 402-2984.

Unfortunately for smokers, however, the Clinical Center will not provide amenities such as shelter and seating for staff and visitors who choose to smoke.

Our policy is clear—don't smoke within 100 feet of any entrance or posted no-smoking area. Smoking is not allowed in the parking garage or in stairwells. When smokers do not comply with this policy, smoke is drawn into the building creating unhealthy and unpleasant conditions for everyone.

Out of consideration for our patients and staff, we ask that smokers respect these rules and that they not litter our grounds with smoking-related trash.

George Simmons's view from the top offers a panorama of the NIH campus. He's a tower crane operator and spends work days towering over the Clinical Center. (Photos by Bill Branson)

Crane operator's office is a room with a view

Editor's note: For months Dr. Alan Zametkin, NIH staff physician, watched an astounding variety of materials float up and down past his fourth floor office window. Steel beams. Buckets of concrete. Carts full of trash and debris. "Given that these exceedingly heavy objects have passed within two to three feet of my window, I wondered who was in fact hauling this vast array of materials so close to my enclave in the Clinical Center," he explained. "Many people at NIH—including me—have marveled at the precision and skill that these crane operators have. I wanted to know more." He had an opportunity to find out more about the man behind the machine just after sunrise one summer morning and shares the story with *CCNews*.

For many, it takes years to climb the ladder to the top of NIH. George Simmons does it in about five minutes a day, five days a week.

Simmons is a tower crane operator for Clark Construction Company. The crane he operates towers over the Clinical Center's east wing. It's one of two 270-footers put into place late last year as part of the NIH Essential Maintenance and Safety Program. The Clinical Center's wings are having their roofs raised to allow installation of new air-handling and safety systems.

A tower crane operator for 17 years, Simmons moves hundreds of tons of massive and unwieldy building materials between narrow canyons of building walls to the top of the Clinical Center.

Simmons's touch at the crane's control panels hasn't always been as deft and true as it is today. "I began operating heavy machine equipment after graduating from high school," he said. "My father operated cranes and heavy equipment, too." During a lunch break one day, the young worker accepted an invitation to climb a crane tower for the first time. He recalls clinging to the ladder with such intensity that his hands literally ached—the classic white-knuckle syndrome. He was absolutely petrified.

But he persisted and gradually, after several more climbs, the fears and anxieties were put to rest. An apprenticeship set him on his way as a professional tower crane operator. In those early days, Simmons worked slowly and hadn't developed his precise skills in placing the crane's hook. Co-workers pouring concrete in 100-degree heat were not inclined to silently and patiently wait for Simmons to hone those skills.

"One guy told me in no uncertain terms that I should go home and never come back," Simmons recalled. And he almost followed that advice. "For the first month, I hated the job and swore I wouldn't continue." But he did continue, mastering the delicate controls of the tower.

(Left) A ladder zig-zags up the 270-foot tower crane that George Simmons operates. (Above) His base of operations is a cozy blue cab that puts a chorus of controls at his fingertips.

Work atop the Clinical Center, he says, is actually much slower paced than the usual construction job because the work doesn't involve constructing a building from the ground up. "At other jobs, we may go two or three weeks working straight through the days without even a lunch break," he said. During peak periods of construction activity, the tower crane operator's skills and talents are in demand as many as twelve hours a day.

Tower cranes, which rent for about $10,000 a month, have dramatically changed the construction industry over the years, Simmons pointed out, because they allow rapid placement of huge amounts of building materials. They appeared on the construction scene in the mid-1960s.

Extremely bad weather usually means a temporary construction halt for most projects, but it takes more than a stiff breeze and a little thunder to bring Simmons down from his perch. The crane is grounded and can take winds of up to 45 miles an hour.

The crane's long arm—jib— isn't locked into place at night and freely moves in the wind acting like a tremendous weather vane. When Simmons is on board the crane, it, by design, can sway as much as five feet at the top. The crane's will flex up to 10 feet, depending on the load being carried. Sometimes Simmons has to walk out to the end of that arm for inspections and maintenance.

Because safety is at the top of every crane operator's agenda, close calls are rare. Simmons remembers one while he was on another job. His shirt accidentally caught on one of his crane's control levers, sending the crane's trolley out over the building they were working on. It snagged a construction worker, who scrambled to attach his safety harness to the crane's hook. When he realized what was happening, Simmons quickly lowered the snagged worker to safety.

Then there are the lighter moments. Like the time Simmons was working on a job in Washington, D.C., hoisting materials off a 13-story building guided only by radio directions from co-workers on the roof.

One item was a toilet that needed to go curbside for cleaning. "The signal man on the roof said, by radio, that the cleaning was finished and to take it back to the roof." But the cleaning wasn't finished and the man doing it was still inside. He made it about 11 floors up before his screaming tipped off the crew and he was sped safely back to ground level.

From a distance, we've admired the skills and coordination of these men behind the machines. Up close, their professionalism is impressive. And we appreciate the efforts of the entire construction team that allow us all to continue our work here into the next century.

—by Dr. Alan Zametkin

Construction takes toll on already-tight parking; campus officials outline options

Looking for a place to park? Well, so have NIH planners.

Beginning this month, campus construction will have an increasing effect on parking—or the lack of it—and campus officials are plotting a multi-level course of action to deal with it. Work associated with the new south entry for the Clinical Center and relocation of Center Drive in preparation for CRC construction will have major impact.

"This isn't 'new' news," points out Stella Serras-Fiotes, master planner in the Division of Engineering Services, facilities planning and programming branch, a part of the NIH Office of Research Services. "We have been working on the parking plan with these losses in mind."

Recently opened temporary lots have already provided some relief. They are located south of lot 41B; in front of the Cloister; near Natcher; by the electrical power station at building 17 (near the Metro); and at NLM . "With the completion of temporary parking lots, we've actually added 100 more spaces than the 300 parking spots that were lost when parking lot 13C closed earlier this summer," Serras-Fiotes said.

Here's what's ahead for August:

•All campus visitor parking will be consolidated Aug. 4 in four pay-for-parking facilities with attendants—the temporary lot at Natcher, the top two-and-a-half levels of MLP-8, part of lot 4A (between buildings 1 and 31), and the P3 level of the parking garage. In P3, there is no parking charge for patients, visitors to patients, and other authorized users. Other current visitor parking will be reassigned to employees (MLP-6, lot 41B and C, lot 31E).

•Parking meters—135 of them—will be installed near building 13, 36, 38, and Natcher.

•Attendant-assisted parking will be instituted for employees who park on the lower levels of MLP-8.

Construction personnel will no longer be able to park in lot 41B. They will have to park off campus, which frees up another 150 spaces for employees.

In September expect:

•Parts of lot 10H, south of the CC's library entrance, will be closed in three phases as work begins on the Clinical Center's new south entry. "The lot will have to be reconfigured to allow for the modified traffic circulation patterns associated with the new entry," explained Serras-Fiotes.

Between Sept. 2 and Oct. 13, work will be along the entire west side of the parking lot. The second phase, expected to continue until Nov. 24, will involve the north side of the lot. The final phase, covering the east and southeast edges, should be complete just after the first of the year. During the first and third phase, about 75 spaces will be lost; up to 140 during the second phase.

•When work to relocate Center Drive begins in September, lots 20A and B—170 spaces—will close.

On tap for October:

•Lot 20C will close. Strike another 100 parking spots.

•Lot 10C, which is between buildings 10 and 49, will lose about 50 spaces in mid-October as the NIH utility tunnel project continues.

•Lots 31A-H are slated to become attendant-assisted parking areas, which will increase capacity for employees by about 330 spaces.

"Since the CC is particularly hard hit by the loss of campus parking, we're considering an option to provide attendant-assisted parking for employees at levels P1 and P2 of the garage, which could increase the capacity by at least 200 spaces," Serras-Fiotes said. That plan would have to wait until completion of repairs to the P1 ramp, expected to begin in mid-August and continue through the end of October.

. . . board meeting covers budget, strategic plan

(Continued from page one)

for independent CC research. Another $7.7 million is earmarked for new equipment, including:

•$100,000 for development of a new molecular diagnostics lab in the Clinical Pathology Department, which is in collaboration with NCI and NHGRI.

•$125,000 for an echocardiogram for Critical Care Medicine.

•$2.55 million for a new 1.5 Tesla magnetic resonance scanner for the Diagnostic Radiology Department.

•And, $1.6 million for Information Systems Department hardware, software and licenses, and telemedicine development.

The FY98 budget reflects essentially the same level of funding as provided in the current budget, a continuing commitment by Dr. Gallin to maintain the quality of services within limited ICD budgets.

About $2.7 million was added to the original $221 million in FY97 with the transfer of two labs to the Clinical Center. They are the Laboratory of Diagnostic Radiologic Research, previously a part of the NIH Office of Intramural Research, and the Multi-Modality Radiologic Imaging Process Systems from NCRR.

The FY98 budget reflects essentially the same level of funding as provided in the current budget . . .

In his update to board members, Dr. Gallin outlined four new projects being developed under the umbrella of the CC's strategic plan.

"I challenged the department heads during our March retreat to come up with ways to identify cost savings in our budget by being creative. The outcome of the retreat was to modify our strategic plan to include four new projects—contract assimilation; management tools; incentives development; and procurement savings."

Major elements for each include:

•Contract Assimilation—conversion of selected large contracts to in-house operations to save money without compromising the quality of care and support offered to the institutes. Contract assimilations under consideration are surgical services and anesthesiology; respiratory care and physiological monitoring; PET technicians; and secretarial and clerical support for the Diagnostic Radiology Department. This initiative could generate up to $2 million in savings, Dr. Gallin told the group.

•Executive information systems—a series of related initiatives aimed at providing institute and CC managers information and tools to maximize productivity. A contract is in the works to analyze what internal management systems exist and how they can be enhanced, Dr. Gallin noted.

Linchpin of this project is a cost-accounting system. "We've never had a cost-accounting system here and we want to develop a good one, or at least evaluate the virtues and cost of having a good one," Dr. Gallin said. "We want to be able to accurately project the cost of all new protocols as they're developed and then use that process to help ICDs track the costs as time goes on."

•Incentives development—a system to reward employees for their cost-savings and productivity. "We need a system for rewarding employees who do a good job in this regard."

•Procurement—purchasing goods at the lowest costs through consolidation of maintenance contracts, equipment standardization, use of the DOD Prime Vendor program, and expanded use of purchase cards.

Dietetic Interns

Graduation ceremonies were held July 25 for the latest group to finish the NIH Dietetic Internship. They are (from left) Susan Holster Hodge, a graduate of Hunter College; Jan Madden, a Hood College graduate; and Marion Vetter, a graduate of Cornell.

Lagana named CC's first chief financial officer

Michele T. Lagana has been named chief financial officer for the Clinical Center.

"This is a new position for the Clinical Center," said Dr. John Gallin, CC director, in announcing the appointment. "Lagana will help us develop a cost-accounting system for the hospital, which will allow us to more closely monitor our budget and track costs. It's central to our efforts in giving CC and institute managers the information and tools they need to enhance productivity and, most importantly, to preserve the quality of research."

"This is an exciting time to be joining the CC team," Lagana said, "with the building of the new CRC, development of more informative financial systems for management decision-making, and establishment of the new governance structure."

Since 1988, Lagana had been assistant vice president and controller at Providence Hospital in Washington, D.C., a 408-bed hospital and 240-bed nursing home.

Prior to that position, Lagana was with the Medlantic Health Care Management Corporation, also in Washington, serving as assistant director of financial analysis from 1976-1987 and assistant director for financial planning from 1984-1986.

Lagana holds a B.A. in finance and economics from Towson State University and earned the M.B.A. from George Washington University. She is a member of the Healthcare Financial Management Association and the Maryland Health Care Coalition.

Michele T. Lagana has been named the Clinical Center's first chief financial officer. Since 1988, she had been assistant vice president and controller at Providence Hospital in Washington, D.C.

Bringing the flag to flower

It was February and CC patient Maynard Bartlett wanted a garden. He meticulously drew out his plan. Flowers—red, white, and blue—in the shape of the American flag. CC staff, patients, volunteers, and friends pitched in to help bring that flag to flower. Admiring the work in progress earlier this summer were (from left) James Truell; Cindy White, certified therapeutic recreation specialist in the Rehabilitation Medicine Department's recreational therapy section; Jan Hass; Mary Meyer, R.N. on 3 East; and Lou Gaeta, also a 3 East staff member. The garden continues to be a cooperative effort—Red Cross volunteers help keep it watered and NIH grounds maintenance staff loaned garden tools. It's on the patio east of the CC's main entrance.

a u g u s t

20 **Grand Rounds**
noon-1 p.m.
Lipsett Amphitheater

Osteogenic Precursor Cells: Utilization for Treating and Modeling Bone Diseases, Pamela Gehron Robey, Ph.D., NIDR

The Clinical Data Repository and Repository Access: New Tools for Retrieving Clinical Data, Tom Lewis, M.D., CC

27 **Grand Rounds**
noon-1 p.m.
Lipsett Amphitheater
Delay of Epiphyseal Fusion: An Experimental Approach for Increasing the Height of Extremely Short Children, Jack A. Yanovski, M.D., Ph.D., CC and NICHD

Schizophrenia in the Age of Molecular Science, David Pickar, M.D., NIMH

***Note**: No Grand Rounds are scheduled for Aug. 6 and Aug. 13.*